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U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Subject: McGuire Nuclear Station
Docket Nos. 50-369, -370
NRC/OIE Inspection Report Nos. 369,370/87-41

Gentlemen:

Pursuant to 10CFR 2.201, please find attached the response to the violation identified in the above referenced inspection report.

Very truly yours,

Hal B. Tucker/jgc

Hal B. Tucker

SEL/215/jgc

Attachment

xc: Dr. J. Nelson Grace
Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta St., NW, Suite 2900
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Mr. W.T. Orders
NRC Resident Inspector
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IE01 1/1

DUKE POWER COMPANY
McGUIRE NUCLEAR STATION
VIOLATION RESPONSE

Violation 50-369/87-41 and 50-370/87-41

Technical Specification 6.8.1 requires that written approved procedures be established, implemented and maintained covering the operation and maintenance of safety related plant equipment.

Station Directive 3.2.2, "Identifying and Performing Plant Retesting", requires that "...all Q.A. Condition - 1, 2, 3 or 4 components, Security Systems and Technical Specification related components shall receive a functional verification prior to returning component to service."

Station Directive 4.2.1, "Handling of Station Procedures", requires that "Station activities shall be conducted in accordance with the provisions of the applicable approved procedure(s)."

TS 3.5.2 requires that two independent Emergency Core Cooling System (ECCS) subsystems [e.g. Residual Heat Removal (ND) pumps] shall be OPERABLE in MODES 1, 2, and 3.

Contrary to the above:

1. On August 28, 1987, licensee personnel performed work on the flow instrument controlling ND Pump 1B recirculation valve, 1ND67B, using a procedure that did not identify the component as being safety related and did not require functional verification subsequent to maintenance. Additionally, the personnel performed corrective maintenance on the component following completion of the routine maintenance without using a procedure or repeating the applicable portions of the completed procedure. These actions ultimately allowed the technicians to leave the instrument isolated, rendering the ND train inoperable. The ND train remained inoperable until September 5, 1987. During the first six days of this period the unit was in MODES 1, 2 and 3, and thus exceeded the 72 hour time period allowed by TS 3.5.2.

2. On September 16, 1987, licensee personnel performed post modification testing of Unit 1 main electrical busline lockout relays on which wiring modifications had been performed. The personnel conducting the tests elected to test beyond the scope and boundaries of the applicable approved procedure. These tests resulted in the actuation of the lockout relay associated with the supply busline to Unit 1, resulting in a loss of offsite power. The loss of the incoming busline also led to a reactor trip on Unit 2 due to a loss of instrument air.

   This is a Severity Level IV violation (Supplement I) and is applicable to Unit 1 only.

RESPONSE TO EXAMPLE NO. 1:

1. Admission or denial of violation:

   Duke admits the violation occurred as stated.

2. Reason for the violation if admitted:

   The violation occurred as the result of personnel error. Two Instrumentation and Electrical (IAE) technicians had performed a routine periodic calibration on flow instrument 1NDLP5050. When they returned pressure switch 1NDPG5050 to service, they found a leak on the fitting. They re-isolated the pressure gauge again and repaired the leak. After completing the repairs, they did not recall unisolating the instrument again. Therefore, the root cause was the failure of the IAE personnel to assure that the instrument was properly returned to service.

3. Corrective steps which have been taken and the results achieved:

   Corrective steps which were taken shortly after discovering the problem were to unisolate the instrument and perform a functional verification of the pump and its recirculation valve.

   Additional corrective measures which were taken were:

   a. The IAE technicians involved in the incident were counseled.

   b. Maintenance personnel revised the PM/PT Work Request computer program for instruments 1&2MNDPG5050 and 1&2MNDPG5051 to reflect the safety related status of the instruments, and added a statement to indicate the work request is potentially a TS item.

   c. Projects personnel made the appropriate arrangements with Design Engineering to initiate a revision to the Unit 2 Instrument detail drawings for 2MNDPG5050.

   d. This incident report, and IE Information Notice No. 85-94, were reviewed with all shift personnel during requalification training.

   e. This incident report was reviewed with all Maintenance supervision to emphasize the need to follow established guidelines if the scope of the work changes, and to emphasize the need to assure complete descriptions of the scope of the work to be performed are used on all work requests.

   f. Compliance personnel revised Station Directive 4.2.1 to be more specific in the requirements for use of procedures when performing station activities.

4. Corrective steps planned to avoid further violations:

   No additional corrective actions are planned.

5. The date when full compliance will be achieved:
   McGuire Nuclear Station is in full compliance with actions described.

RESPONSE TO EXAMPLE NO. 2:

1. Admission or denial of violation:

   Duke admits the violation occurred as stated.

2. Reason for the violation if admitted:

   This violation was the result of personnel error. Relay personnel did not thoroughly trace the applicable McGuire Electrical Elementary Drawings before doing additional relay checkout. Contributing to this incident is the fact that Instrumentation and Electrical personnel and Relay personnel tested beyond the scope and boundaries of the post modification test procedure.

3. Corrective steps which have been taken and the results achieved:

   a. Station Directive 4.2.1 has been revised to emphasize adhering to approved station procedures.

   b. IAE and Relay personnel tested the 1B Busline associated lockout relays using TT/1/A/9100/206, Functional Verification of the "Lockout" Relays and Associated Indicating Lights, which was changed to include specific steps necessary to perform adequate verification of lockout relay modifications.

   c. The Station Manager communicated the importance of using and not exceeding (or deviating from) the established directions of existing procedures to appropriate station personnel.

   d. The General Manager of Nuclear Support evaluated, with the Vice President of Transmissions (Relay) the need to identify and write procedures for all activities that Transmissions personnel perform which could be of safety consequence (Reactor Trip, Blackout, etc.).

   e. Transmission Department personnel involved were trained in the use of procedures and the procedure change process required when a procedure is judged inadequate.

4. Corrective steps planned to avoid further violations:

   No additional corrective actions are planned.

5. The date when full compliance will be achieved:

   McGuire Nuclear Station is in full compliance with corrective steps described.